



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 7 2005

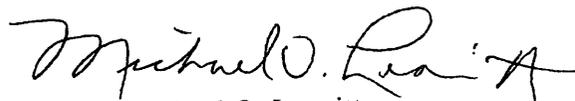
The Honorable Richard B. Cheney
President of the Senate
Washington, DC 20510

Dear Mr. President:

I am respectfully submitting the enclosed report, entitled "Medicare Contracting Reform: A Blueprint for a Better Medicare." This report to Congress is in response to requirements of section 911(g) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173. This law mandates that the Secretary of Health and Human Services eliminate the current Title XVIII contracting authority and replace it with the new Medicare Administrative Contractor (MAC) authority. The law also requires that all work performed by the current Title XVIII contractors be competed under the new MAC authority by October 1, 2011.

The enclosed report details the steps the Department of Health and Human Services intends to take to implement the new MAC authority. I am also sending a copy of this letter to the Speaker of the House of Representatives and to the Comptroller General of the United States.

Sincerely,


Michael O. Leavitt

Enclosure



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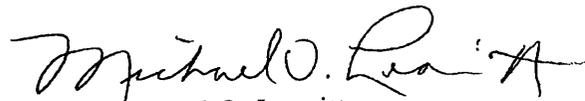
The Honorable J. Dennis Hastert
Speaker of the House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

I am respectfully submitting the enclosed report, entitled "Medicare Contracting Reform: A Blueprint for a Better Medicare." This report to Congress is in response to requirements of section 911(g) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173. This law mandates that the Secretary of Health and Human Services eliminate the current Title XVIII contracting authority and replace it with the new Medicare Administrative Contractor (MAC) authority. The law also requires that all work performed by the current Title XVIII contractors be competed under the new MAC authority by October 1, 2011.

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The Honorable David M. Walker
Comptroller General of the
United States Government Accountability Office
Washington, DC 20548

Dear Mr. Walker:

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Sincerely,

A handwritten signature in cursive script that reads "Michael O. Leavitt".

Michael O. Leavitt

Enclosure

REPORT TO CONGRESS

MEDICARE CONTRACTING REFORM:

A BLUEPRINT FOR A BETTER MEDICARE

MICHAEL O. LEAVITT
SECRETARY OF HEALTH AND HUMAN SERVICES
2005

Executive Summary

Under section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress mandated that the Secretary of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act (the Act) with the new Medicare Administrative Contractor (MAC) authority. This reform (referred to as Medicare contracting reform), intended to improve Medicare's administrative services to beneficiaries and health care providers, will bring standard contracting principles to Medicare, such as competition and performance incentives, which the government has long applied to other federal programs under the Federal Acquisition Regulation (FAR). Using competitive procedures, Medicare will replace its current claims payment contractors – fiscal intermediaries (FIs) and carriers – with new contract entities, MACs. The MMA requires that the Centers for Medicare & Medicaid Services (CMS) compete and transition all work to MACs by October 2011.

The Vision of the Future Medicare Fee-for-Service Environment

CMS' vision for Medicare fee-for-service (FFS) is that of a premier health plan that allows for comprehensive, quality care and world-class beneficiary and provider service. Achieving this vision requires substantial improvement of CMS' current FFS administrative structure. Although the Medicare contracting reform provisions contained in section 911 provide significant improvements to the structure, CMS must embark on additional program improvements in order to realize its vision.

To meet the needs of its growing beneficiary population with the retirement of the Baby Boom generation, Medicare will establish a single point-of-contact for the information needs of Medicare beneficiaries and providers of health care services. For beneficiaries, the single point-of-contact will be 1-800-MEDICARE, which will take them through a highly advanced and coordinated customer service network. Providers will use the MACs (identified under section 911) as their primary point-of-contact for conducting all claims-related business and obtaining information on behalf of their patients. In addition to improving its customer service, CMS will make advances toward the delivery of comprehensive care by integrating Medicare Parts A and B under the MACs and creating a modernized administrative IT platform to provide a central location for the storage and management of Medicare data.

Funding and Resources

The investment for the implementation of Medicare contracting reform will help ensure the program remains an important and secure health plan for beneficiaries. The President's Budget for FY 2006 requests \$58.8 million in discretionary funds to support the implementation of Medicare contracting reform. The plan set forth in this Report will require a significant additional investment in subsequent years, particularly in FYs 2007 and 2008. These resources will be needed in order to fund a number of critical transition activities, including costs associated with the close-out of the current Medicare FI and carrier contracts. The out-year cost estimates are consistent with Congressional Budget Office cost estimates relating to the legislative proposals that evolved into section 911 of MMA.

Although Medicare contracting reform requires a significant up-front investment, this initiative will also generate significant trust fund and administrative savings over time. Assuming that the transition schedule discussed in [Chapter III](#) is maintained, the trust fund savings resulting from Medicare contracting reform will start in FY 2008 and will accumulate rapidly to a total of \$900 million by the end of FY 2010. Beyond FY 2011, CMS projects that administrative savings, in the form of contractor cost reductions from the competitive contracting environment, could exceed \$100 million annually.

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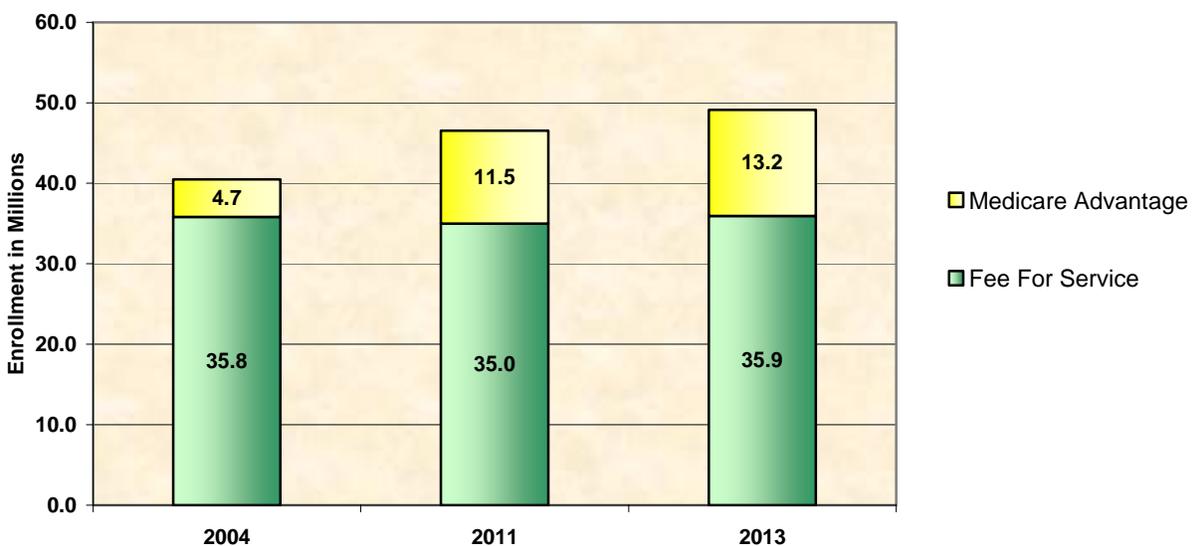
Chapter I: Introduction

Medicare provides health care security to approximately 42 million Americans. Since its creation in 1965, the program has played a crucial role in guaranteeing insurance coverage, improving access to care, protecting incomes, and lengthening life expectancy of the nation’s elderly and some people with disabilities, and has helped to facilitate important enhancements in overall health care quality.

Many of Medicare’s achievements are attributable to the fee-for-service (FFS) portion of the program, also known as the “Original Medicare Plan,” a pay-per-visit health plan that allows program beneficiaries to go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. Under FFS, a beneficiary pays a deductible, then Medicare pays its share of the Medicare-approved amount, and the beneficiary pays his remaining share. Today, nearly 36 million beneficiaries representing 86 percent of the program’s overall caseload rely on Medicare FFS for their health care needs.

As successful as Medicare has been, however, the program’s current administrative structure—in particular, the way in which it has used contractors to pay FFS claims—has not kept pace with decades of dramatic improvements in healthcare. Its outdated business processes and, in some cases, technologies are no match for the country’s evolving health care delivery system and are ill-equipped to handle the even greater challenges that lie ahead, such as the oncoming retirement of the “Baby Boom” generation. Although beneficiary enrollment for Medicare Advantage increases under the reforms provided in the MMA, Figure I-1 shows that Medicare FFS will continue to represent the majority of overall Medicare enrollment in the future.

Figure I-1: Comparison of Overall Medicare Enrollment by Fiscal Year¹



¹ Medicare Advantage and Medicare FFS enrollment figures (Part A) from fiscal year 2006 President’s Budget.

Seizing the opportunity to create a Medicare administrative structure that is capable of meeting current and future health care delivery challenges, in 2003 Congress passed a major reform of Medicare's contracting provisions². This reform, intended to improve Medicare's administrative services to beneficiaries and health care providers, expands competition beyond traditional health insurers for Medicare's claims-payment business for the first time in the program's 39-year history, and requires an extensive overhaul of Medicare's administrative structure.

This report outlines the Centers for Medicare & Medicaid Services (CMS) plan for implementing the Medicare contracting reform mandated by Congress, as well as other improvements to the Medicare administrative structure.

Medicare Contracting Today

From Medicare's start, the federal government has used private insurance companies to process claims and perform related administrative services for the program's beneficiaries and health care providers. Today, CMS relies on a network of contractors to process nearly 1 billion Medicare claims each year from over 1 million health care providers. In addition to processing claims, the contractors enroll health care providers in the Medicare program and educate them on Medicare billing requirements, handle claims appeals, and answer beneficiary and provider inquiries.

Nearly 36 million, or 86 percent, of today's Medicare beneficiaries receive benefits through the fee-for-service portion of the program.

At present, the contractors include 25 fiscal intermediaries (FIs) and 18 carriers that process FFS claims. FIs process claims for Medicare Parts A and B for facilities, including hospitals and skilled nursing facilities. Carriers process claims for Medicare Part B, in particular for physician, laboratory and other services. In addition, 4 fiscal intermediaries serve as regional home health intermediaries (RHHIs), concentrating exclusively on home health and hospice claims. Similarly, 4 carriers serve as durable medical equipment regional carriers (DMERCs), focusing exclusively on claims for durable medical equipment, prosthetics, orthotics and supplies. ([Appendix A](#) contains a list of current contractors.)

Contractors process claims for specific jurisdictions. Because of the way Medicare contracts have evolved over 39 years, these jurisdictions can encompass a single county, a single state, a block of states, or several states in different areas of the country. Some contractors serve only one state, and others serve several, sometimes non-contiguous states, resulting in a patchwork of responsibility and service. In addition, some contractors are both FIs and carriers, but do not serve the same geographic areas in both lines of business. ([Appendix B](#) contains the current jurisdictional maps for FIs, carriers, RHHIs, and DMERCs.)

FI and carrier contracts now vary substantially in the number of beneficiaries served and in the number of claims processed. The 6 largest FIs and 7 largest carriers handle more than 60 percent of all FFS claims. The largest FI processes more transactions than the 17 smallest FIs combined,

² The major reform of Medicare contracting provisions is contained in section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, or Public Law 108-173), signed into law by President George W. Bush in December 2003.

while the largest carrier processes more claims than the 8 smallest carriers combined. This variation presents CMS with challenges for managing operational costs and risks, and poses difficulties in ensuring that outreach and information provided to Medicare beneficiaries and providers is uniform.

The Need for Reform

Although health care delivery in the United States has evolved with four decades of advances in medicine and technology, the contracting portion of Medicare's FFS administrative structure has not. The reforms mandated by Congress grew out of the gradual realization that Medicare's ability to deliver more efficient and effective services to beneficiaries and health care providers and meet future programmatic challenges is hampered by a number of restrictions and weaknesses in the current administrative system. They include:

- ***Lack of full and open competition.*** FFS claims processing contracts for Parts A and B are competed to a limited number of contractors, who may or may not be the most qualified organizations to conduct the work. Provider institutions, such as hospitals, nominate FIs to process Part A claims, which limits CMS' ability to manage the program more effectively. The Secretary of Health and Human Services is required, by law, to choose Part B carriers from a small pool of companies; specifically, only from health insurance companies.
- ***Separate processing of Part A and Part B claims.*** Part A and Part B claims are processed by separate claims processing contractors and systems, with few exceptions. These multiple interfaces with Medicare increase the frustration for beneficiaries and providers by making it difficult to get answers on coverage questions quickly. Providers also face increased expenses due to separate processing, and have less ability to freely understand and coordinate, where appropriate, services on behalf of their patients.
- ***Specialization restrictions.*** CMS is limited in its ability to award separate contracts for individual claims administration activities in which certain companies may excel, such as in operating data centers or educating providers about program policies.
- ***Absence of performance-based incentives.*** Contractors work under cost-based reimbursement contracts where they are reimbursed for necessary and proper costs of carrying out Medicare activities, but do not have financial incentives to improve their performance.
- ***Cumbersome termination procedures.*** Contractors may terminate their contracts without cause, simply by providing 180 days notice. CMS, on the other hand, must demonstrate that a poor performing or unresponsive contractor has failed substantially to carry out its contract, or that continuation of the contract is disadvantageous or inconsistent with the effective administration of Medicare before it is able to terminate a contract. It must also provide the contractor an opportunity for a hearing before termination.

- **Outdated information technology.** Medicare’s information technology (IT) infrastructure is inadequate for the program’s expanding needs and fails to take advantage of current technologies (e.g., use of the Internet to submit/track claims) that would improve customer service and result in additional cost savings.

Improving Medicare Contracting: Medicare Administrative Contractors and Other Changes

Section 911 contains several important changes to Medicare’s administrative structure that will make contracting dynamic, competitive, and performance-based and ensure the program is more responsive to the needs of its beneficiaries and health care providers.

In contracting, the most dramatic change within the FFS environment will bring standard contracting principles to Medicare, such as competition and performance incentives, that the government has long applied to other federal programs under the Federal Acquisition Regulation (FAR). Using competitive procedures, Medicare will replace its current claims payment contractors – FIs and carriers – with new contract entities, Medicare Administrative Contractors (MACs). The MMA requires that CMS re-compete and transition all work to MACs by 2011.

The changes to contracting and other aspects of Medicare’s administrative structure under section 911 include the following:

- **Competition.** CMS will fully and openly compete contracts for services related to claims payment, especially those geared to the 1.2 million providers and physicians who bill for health care services delivered to beneficiaries.
- **Beneficiary-centered benefit administration.** Contracting services for Parts A and B will be consolidated to provide beneficiaries and providers with a unified Medicare point-of-contact; create a modernized administrative IT platform; and improve beneficiary and provider access to information through consolidated, standardized administrative services, all of which will result in the ability to provide more comprehensive and higher-quality care for beneficiaries.
- **Contract performance incentives.** Contracts will pay performance incentives, allowing contractors to earn profits when they are more efficient, innovative, and cost-effective and deliver better administrative services to beneficiaries and providers.
- **Improved contractor management.** Using Medicare’s new contracting authority, CMS will compete contracts among a broader range of private sector organizations, allowing for increased competition and cost efficiencies, and strengthen its ability to manage contractors based on performance (e.g., termination for poor performance).
- **Re-competition.** CMS will compete all contracts within the initial cycle and then periodically re-compete them at least once every five years.

[Table I-1](#) details benefits that improving Medicare contracting will provide to the program’s beneficiaries and health care providers.

Table I-1: Improving Medicare Contracting: Benefits for Medicare Beneficiaries and Providers

| Beneficiaries | Providers |
|---|---|
| <ul style="list-style-type: none"> National approach to all program inquiries from people with Medicare | <ul style="list-style-type: none"> Unified Medicare point-of-contact to eliminate multiple interfaces with the program |
| <ul style="list-style-type: none"> Better able to participate in managing their own care by having improved access to their claims history | <ul style="list-style-type: none"> Better facilitation of coordination of care and management of effective service utilization |
| <ul style="list-style-type: none"> Innovation will help improve healthcare quality and boost productivity, accuracy, and reliability | <ul style="list-style-type: none"> Competition will encourage contractors to deliver better service to providers |
| <ul style="list-style-type: none"> Modernized IT systems enable more efficient processing of beneficiary claims | <ul style="list-style-type: none"> Contractor performance incentives will help improve the level of quality and service to providers. Providers will be able to participate in the evaluation of contractors through surveys |

Content of Report

This report, which outlines CMS’ plan for implementing the Medicare contracting reform provisions contained in section 911 and other improvements to the Medicare administrative structure, is organized as follows:

| | |
|-----------|--|
| Chapter 1 | <u>Introduction</u> : Describes the reasons for and intent behind Medicare contracting reform and provides background on the current Medicare FFS environment. |
| Chapter 2 | <u>Building a Strong Medicare FFS Environment for the 21st Century</u> : Describes CMS’ vision for the future Medicare FFS environment. |
| Chapter 3 | <u>Plan for Implementing Medicare Contracting Reform and Related FFS Initiatives</u> : Describes how CMS intends to implement Medicare contracting reform, and discusses upcoming milestones and major timelines as outlined in section 911. |
| Chapter 4 | <u>Resources and Funding</u> : Describes the expected funding and expenditure levels anticipated by the current Medicare contracting reform plans. |
| Chapter 5 | <u>Key Accomplishments to Date</u> : Describes significant work accomplishments to date in several key areas related to Medicare contracting reform implementation. |

In addition, this report includes several appendices, which are referenced throughout the document.

Chapter II: Building a Strong Medicare FFS Environment for the 21st Century

CMS' mission is to ensure health care security for beneficiaries. A major component in achieving this mission is the successful administration of Original Medicare, or Fee-for-Service (FFS) Medicare. CMS' vision for FFS Medicare is that of a premier health plan that allows for comprehensive, quality care and world-class beneficiary and provider service. Achieving this vision requires substantial improvement of CMS' current FFS administrative structure. Recent legislation greatly facilitates CMS' efforts in this regard.

This chapter outlines CMS' vision for the future Medicare FFS environment. It reflects CMS' commitment to ensuring that today's changes to Medicare's administration will continue to benefit its customers as the enrollee population increases with the retirement of the Baby Boom generation, and well into the 21st century. Through its vision, CMS plans to shape its implementation of Medicare contracting reform and other related initiatives in three areas that are critical to improving beneficiary and provider experiences with the program: beneficiary customer service, provider customer service, and delivery of comprehensive care.

Beneficiary Customer Service

For many Medicare beneficiaries with questions about Medicare coverage, a contractor's customer service department is their first exposure to the program. Unlike today, when a person may have to call multiple entities to get the answer to a question, CMS envisions a future Medicare environment that provides people with Medicare "one-stop shopping" for all their program inquiries and requests.

Beneficiaries will have a single point-of-contact connecting them to a seamless operations network for meeting their information needs, including complex Original Medicare Plan inquiries in addition to other inquiries, such as the availability of prescription drug coverage and finding and comparing nursing homes. A beneficiary's first point of entry for resolution of questions about Medicare coverage will be 1-800-MEDICARE, which will take them through a more advanced customer service network. This network will make use of standard and advanced customer service tools and techniques, such as interactive voice response (IVR) systems, updated and new data systems that provide customer service representatives access to beneficiary- and claims-specific information, and processes for referring complex inquiries.

The following scenario compares the current model to CMS' vision for beneficiary customer service under the future FFS environment.

BENEFICIARY CUSTOMER SERVICE EXAMPLE

Mr. Jones suffers a stroke, which leaves him paralyzed on the left side. His recovery requires speech and physical therapy as an inpatient and the use of an electric wheelchair upon his return home. Mr. Jones is sent home in an electric wheelchair after stays at both an acute care hospital and a rehabilitation facility.

When Mr. Jones's medical bills start coming in, his daughter has several questions regarding the charges for the inpatient hospital and rehabilitation stays, physician services, and electric wheelchair. She calls 1-800-MEDICARE.

Today's FFS Environment: An IVR answers and offers the option to use the IVR or speak with an operator. Ms. Jones opts to speak with an operator. Since Ms. Jones's questions are specific to certain claims and dates of service, the operator transfers her three times. Once for the FI, which processed the inpatient hospital and rehab facility claims; once for the carrier that processed the physician service claims; and once for the DME regional carrier that processed the electric wheelchair claims. Ms. Jones must deal with each individually, repeating information she has stated on a previous call. If follow up is necessary, she must do so with three different entities.

Future FFS Environment: An IVR answers and offers the option to use the IVR or speak with an operator. The operator, supported by the Next Generation Desktop (NGD) offering access to claims-specific information, addresses Ms. Jones's status questions about all of her father's claims. In the course of the conversation, Ms. Jones mentions another issue that her father is having related to Medicare. The operator recognizes that this is an issue for which no scripting is available in the NGD. The operator then opens a complex inquiry referral capturing all of the pertinent information in the NGD. The operator informs Ms. Jones that the referral will be sent to the appropriate MAC and that she should hear from the MAC shortly. The complex inquiry referral is captured in the NGD so that the appropriate MAC will retrieve the referral and take action to resolve the issue. Once the referral is made, the MAC has sole responsibility for addressing and resolving the issue and providing information back to the beneficiary.

Provider Customer Service

Providers face problems similar to beneficiaries when they need to interface with Medicare. In the current FFS environment, providers must deal with multiple contractors to conduct business on behalf of their patients concerning the receipt, processing, and payment of claims. Their ability to quickly check on the status of a claim is further limited by the lack of an online resource that might allow them to access claims processing information.

CMS' vision for provider customer service in the future includes providers interacting with Medicare through MACs. The MACs would be the providers' single point-of-contact for conducting all claims-related business and obtaining information on behalf of patients. In addition, the agency intends to make use of advancing technology to create a web portal that would make it easier for providers to get the information they need (e.g., checking claims status, beneficiary eligibility, and submitting claims via a secure Internet connection). Modernized IT systems will facilitate provider access to Medicare systems, enabling the program to better serve providers and improve claims payment.

The following scenario compares the current model to CMS' vision for provider customer service under the future FFS environment.

PROVIDER CUSTOMER SERVICE EXAMPLE

Dr. Kildare, having cared for Mr. Jones in both the hospital and at the rehabilitation facility, has questions regarding the status of several of the claims she submitted for that care, as well as about the unique medical necessity documentation for a wheelchair ordered for Mr. Jones from a supplier, Helping Hands Medical Supply. The supplier is enrolled at a DMERC, which requires a physician to document medical necessity as a condition of payment.

Today's FFS Environment: Dr. Kildare submitted claims for services provided to Mr. Jones to his carrier. Dr. Kildare is enrolled to provide services in the Medicare program through her carrier and she and her staff have frequent contact with her carrier for a variety of reasons (e.g. claim status, eligibility), usually through a toll-free phone line. Because she is not enrolled as an FI provider, she is not able to get any information on services provided in the hospital or rehabilitation facility because those claims are processed by an FI. In this case, 2 FIs are involved because the hospital uses a local FI but the rehabilitation facility is a chain that uses an FI in Nebraska. In order to ask the medical necessity documentation question, Dr. Kildare must determine which DMERC has jurisdiction over Mr. Jones's wheelchair claims. This jurisdiction is based on Mr. Jones's residence. Dr. Kildare finds herself needing information from 4 contractors, three of which are new to her. She is not sure how to proceed.

Future FFS Environment: Dr. Kildare interacts with a MAC that processes both Part A and B claims and can therefore offer broader claims information for an individual beneficiary. Dr. Kildare calls the MAC's toll-free line. Dr. Kildare is able to access both Part A and B claims information for the beneficiary, Mr. Jones. The MAC, as the physician's portal to the Medicare program, assists Dr. Kildare to reach the DME MAC and makes sure Dr. Kildare understands the unique medical documentation required. The MAC minimizes the number of contractor interactions and supports the provider as a business partner working to ensure that beneficiaries get the medical care needed while minimizing the hassle factor.

Infrastructure for Comprehensive Care

The current FFS environment features procedures that have different claims for the same patient being processed by separate contractors and antiquated IT systems that are unable to easily show the complete care received. These boundaries make it extremely difficult for Medicare to identify overall patterns of beneficiary care.

CMS envisions a future FFS environment where providers will have the ability to deliver comprehensive care to patients through patient-centered benefit administration. CMS will achieve comprehensive care by integrating claims processing for Medicare Parts A and B, and creating a modernized administrative IT platform that incorporates the latest technological advances and standardization practices.

Medicare data across all benefits will be collected and combined to provide a comprehensive view of a beneficiary's care, including recent hospitalizations, physician visits, and prescription drugs. Development of this capacity will greatly facilitate the achievement of a comprehensive care environment.

The new Chronic Care Improvement Program demonstrates the possibilities for comprehensive care. Under this program, provider organizations will work to ensure beneficiaries adhere to their individual plans of care and seek appropriate medical attention in the management of certain chronic conditions, to improve the overall quality of care for beneficiaries.

Chapter III: Plan for Implementing Medicare Contracting Reform and Related FFS Initiatives

In 2004, CMS updated its business plan for Medicare FFS administrative operations to ensure its strategic goals reflect the Medicare contracting reform changes mandated by Congress as well as the agency's own vision for the future FFS environment. Figure III-1 shows the major strategic goals for FFS administrative operations.

Figure III-1: Major Strategic Goals for Medicare FFS Administrative Operations

| STRATEGIC GOALS FOR MEDICARE FFS ADMINISTRATIVE OPERATIONS |
|---|
| Consolidation of claims workloads and systems to further ensure the accurate and timely payment of claims and achieve economies of scale for processing larger workloads |
| Integration of Part A and Part B claims processing and IT modernization to achieve patient-centered benefit administration and establish a single point-of-contact for health care providers |
| Compensation commensurate with performance and accountability to bring higher levels of service and innovative management approaches to Medicare |
| Specialization of contracts to align scarce resources with important benefit administration functions and maximize flexibility in program operation and risk management |
| Optimization of contractor management and oversight to improve the overall functioning of the Medicare program |

This chapter describes CMS' plan for implementing the Medicare contracting reform provisions contained in section 911 to achieve the strategic goals for Medicare FFS administrative operations. The initial implementation phase, scheduled for 2005-2011, will focus on implementation of the MACs as well as other related FFS initiatives. Combined, they create a roadmap CMS will follow to improve Medicare's administrative structure and achieve the future FFS environment through work in the following three areas:

- **Medicare Administrative Contractors.** In the future FFS environment, MACs will assume work currently performed by FIs and carriers, and serve as providers' primary point-of-contact for the receipt, processing, and payment of claims.
- **Functional contractors.** Functional contractors will perform work around a single Medicare program function, such as claims appeals, and provide increased efficiency in the management and delivery of services to beneficiaries and providers.
- **IT improvements.** Modern, integrated IT systems will improve overall processing of claims and allow providers to not only electronically submit claims, but also check beneficiary eligibility and claims payment status.

Medicare Administrative Contractors

MACs will assume the claims payment work that is now performed by FIs and carriers. CMS plans to compete and award 23 MACs during the initial implementation phase (2005-2011). CMS will award 15 Primary A/B MACs servicing the majority of all types of providers, 4 specialty MACs servicing the majority of home health and hospice (HH) providers, and 4 specialty MACs servicing durable medical equipment (DME) suppliers.

The MACs will serve as the providers' primary point-of-contact for the receipt, processing, and payment of claims. These contractors will perform all core claims processing operations for both Part A and Part B. MACs will also maintain the same level of knowledge and experience among employees that exists today at the FIs and carriers. Furthermore, CMS will ensure its MAC contracts focus on three critical areas:

Customer Service. MACs will serve as the providers' primary contact with Medicare, and CMS will hold MACs accountable for overall provider satisfaction with their services. The quality of MAC services delivered to providers will also have an impact on beneficiary satisfaction with the program. CMS will develop performance requirements and standards for MACs through consultations with providers and beneficiaries, which will help ensure that the requirements produce desired results.

Operational Excellence. MACs will be required to maintain operational excellence, effectively manage the use of employees and information systems, and accomplish program goals. In addition, CMS will encourage MACs to foster efficiencies in the administration of Medicare to promote the best value to the government. MACs will also be responsible for utilizing new IT resources to promote interactions with providers and beneficiaries.

Financial Management. MACs will promote the fiscal integrity of Medicare and be accountable stewards of public funds. They will pay claims in a timely, accurate, and reliable manner while promoting cost efficiency and the delivery of maximum value to the customer. MACs will also be responsible for properly interfacing with Medicare accounting systems and setting up adequate internal controls within their operations.

MAC Jurisdictions

The Primary A/B MACs will operate in 15 distinct, non-overlapping geographic jurisdictions, which will form the basis of the Medicare FFS claims processing operation. The arrangements for the 8 specialty MACs (for DME and HH services) will reflect a realignment of the existing jurisdictions for RHHIs and DMERCs to fit the boundaries of the 15 Primary A/B MAC

Current FFS Environment

- 51 contractors operating in multiple, sometimes overlapping jurisdictions
- Separate contractor responsibilities for processing Part A and Part B claims
- No single Medicare point-of-contact for providers on claims-related inquiries

Future FFS Environment

- 23 MACs operating in distinct, non-overlapping jurisdictions
- MACs perform core claims processing for both Part A and Part B claims
- Providers interface with Medicare through MACs—their single point-of-contact with the program for claims-related inquiries

jurisdictions. CMS believes this strategy will reduce the operational risk and cost of initial implementation, while preserving significant benefits to these types of providers.

CMS designed the new MAC jurisdictions according to three criteria: promote competition, balance the allocation of workloads, and account for integration of claims processing activities. The result is jurisdictions that reasonably balance the number of FFS beneficiaries, practitioners, and claims. While these jurisdictions exhibit some variations in size and workload, they are more equalized than the existing FI and carrier assignments³.

MAC Acquisition and Transition Schedule

CMS plans to compete the existing FI, carrier, RHHI, and DMERC workloads beginning with a start-up acquisition and transition cycle focused on a small discrete workload followed by 2 MAC acquisition and transition cycles. [Appendix C](#) depicts the schedule for the procurement plan, with the first MAC procurement beginning by FY 2005. CMS anticipates each acquisition cycle—from solicitation to award—will take approximately 9 to 12 months, and estimates the subsequent transition of workload from existing contractors to new MACs will range from 6 to 13 months after a MAC award. The full FFS contracting workload will be transitioned to MACs by October 2009.

The start-up cycle will compete the current DMERC workloads and one Primary A/B MAC. The comparatively small and stable nature of these workloads will allow CMS to examine its acquisition and transition efforts, and apply lessons learned to future cycles as well as train new personnel on specific activities.

Cycles One and Two will compete and transition the balance of the FFS workload. These cycles will subject greater than 40 percent of the national workload to competition and transition at a single time. In addition, the cycles will require substantial risk management and schedule precision to minimize possible operational disruption. Table III-1 provides a percentage breakdown of the total Medicare workload transitioned by MAC cycle.

Table III-1: Percentage of Medicare Workloads Transitioned to MACs

| | Start-Up Cycle | Cycle One | Cycle Two |
|--|-------------------|-----------|-----------|
| % of National Workload Transitioned | 8.8% | 44% | 47.2% |
| Cumulative % | 8.8% | 52.8% | 100% |

This schedule allows greater savings to accrue to the Medicare program faster by moving large amounts of the FFS workload in a short period of time. CMS believes the initial start-up cycle with the subsequent rapidly phased implementation approach:

- Balances the urgency of achieving operational and programmatic savings with the need to manage the operational risk of disrupted service to beneficiaries and providers, and

³ Based on FY 2001 analysis, the new MAC jurisdictions range from between 1.1 and 3.4 million beneficiaries, and between 21,000 and 76,000 physicians.

- Maximizes efficiency in managing the MACs.

This schedule also provides flexibility within the mandated implementation timeframe (2005-2011) to allow CMS to monitor each procurement. CMS may adjust the planned schedule as needed in order to ensure continuity in claims payment and processing.

Tactical Plan for Start-Up Cycle Competitions

In order to issue the first contract solicitation for DMERC workloads by spring 2005, CMS will adhere to the following milestones:

- **Early 2005** – As part of our continuing market research, CMS will release a draft Request for Information on which CMS will solicit comment and feedback.
- **February 2005** – CMS will issue the initial Primary A/B MAC Statement of Work (SOW) for public comment.
- **March 2005** – CMS will release a formal Request for Proposal (RFP) through FedBizOpps.
- **September 2005** – CMS will release a formal Primary A/B MAC RFP through FedBizOpps.
- **December 2005** – CMS will award the DME MAC contracts and will immediately begin necessary transitions.
- **June 2006** – CMS will award the first Primary A/B MAC contract and immediately begin necessary transitions.

This first competition will mandate that CMS complete key reengineering activities as well as applicable acquisition requirements. CMS will complete all necessary actions to compete, award, and manage the first MACs, while acknowledging that it will modify successive procurements to incorporate comments and lessons learned.

Functional Contractors

In the future FFS environment, CMS will maintain its relationships with functional contractors that have increased the efficiency of Medicare services for beneficiaries and providers. For example, functional contractors may serve a broader purpose than just a FFS function, it may be cost effective to consolidate into fewer contractors, or there is a need for an independent party to perform a function. These include the coordination of benefits (COB) contractor and program safeguard contractors (PSCs). In addition, CMS will implement additional functional contractors that will also bring benefits to beneficiaries and providers. These include qualified independent contractors (QICs) for Medicare appeals, beneficiary contact centers, and data centers. Lastly, as part of its comprehensive management of Medicare FFS, CMS will continually evaluate additional areas where functional contractors will bring advantages to beneficiaries and providers, while providing administrative benefits to the program.

Coordination of Benefits Contractor

CMS established one COB contractor to consolidate pre-pay Medicare secondary payer activities among all FFS contractors. In the future FFS environment, the current COB contractor will operate in conjunction with the MACs. The COB contractor is responsible for identifying the health benefits available to a Medicare beneficiary and coordinating the payment process to prevent erroneous payments.

Qualified Independent Contractors

Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 requires CMS to contract with QICs to provide a second-level of appeal, reviewing redeterminations of FIs and carriers. The QIC reconsideration is a new level of appeal that did not previously exist for Part A claims, and will replace the fair hearing level of appeal for Part B claims.

QICs will achieve improvements in fairness, consistency, and efficiency of the appeals process. These improvements follow from a more independent process, greater reliance on physician reviews, standard protocols, and an improved data system.

CMS has procured QIC services through FAR contracts that will permit the agency to build in meaningful cost containment incentives and an evaluation/performance improvement process. CMS awarded contracts to approved QICs in September 2004. CMS anticipates awarding the first task orders to conduct QIC reconsiderations in early calendar year 2005. CMS expects to have QICs conducting all second-level appeals by the end of FY 2005.

Program Safeguard Contractors

CMS created PSCs under the authority of the Medicare Integrity Program (MIP), created by the Health Insurance Portability & Accountability Act of 1996, to give greater focus to program safeguard activities: the review of provider activities, including medical, utilization, and fraud reviews; cost report audits; Medicare secondary payer determinations; and provider and beneficiary education regarding program integrity. Although the MMA allows MACs to be awarded contracts that include MIP functions, CMS expects PSCs will continue to perform these activities in the future FFS environment, coordinating closely with the MACs.

Beneficiary Contact Centers

In the future FFS environment, beneficiaries will have a single Medicare point-of-contact – a 1-800-MEDICARE call center operated by CMS – that will connect them to a seamless network of customer service entities that can answer Medicare and related questions and resolve problems. A key part of the customer service network will be new Beneficiary Contact Centers (BCCs). The call center will route claims-specific inquiries to the BCCs, which will be operated by companies under contract with CMS.

Current FFS Environment

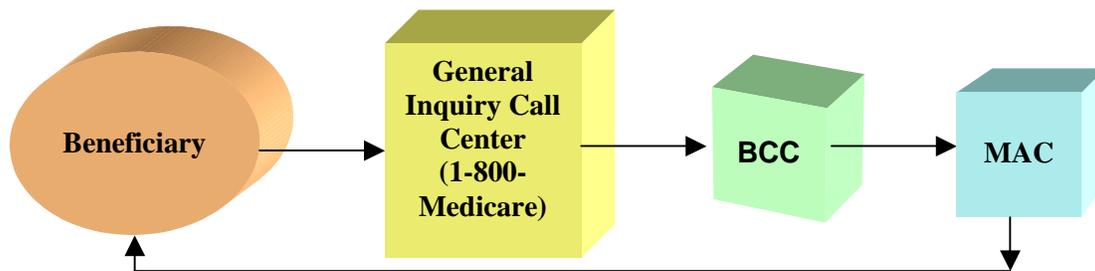
- Limited use of functional contractors
- Inconsistent levels of service to beneficiaries and providers
- CMS has limited ability to manage system improvements, funding allocations, and claims workloads

Future FFS Environment

- Expanded use of functional contractors to gain greater efficiencies in servicing beneficiaries and providers
- Increased consistency in service levels
- Web-based services, integrated help desks and call centers improve services for beneficiaries and providers

Although they will not have a primary role in beneficiary customer service, MACs will support the 1-800-MEDICARE call center and the BCCs as a research center/responder for complex beneficiary inquiries. For example, a BCC may refer an inquiry it cannot resolve to the MAC that originally processed the claim. The MAC will then take ownership of the inquiry and respond directly back to the beneficiary. In handling these complex inquiries, the MAC will use Next Generation Desktop (NGD), a web-based desktop system that provides access to information for answering beneficiary inquiries, to receive referrals, and to record their resolutions. Figure III-2 depicts the process for responding to beneficiary inquiries in the future FFS environment.

Figure III-2: Beneficiary Inquiry Process



IT Improvements

One goal of Medicare contracting reform is to integrate functions and processes to improve service to beneficiaries and providers, and to enhance the data that CMS uses to administer FFS Medicare. Currently, data is not sufficiently integrated to allow CMS to capitalize on innovations in the business and science of health care. Moreover, the agency's IT platform cannot be sufficiently secured to allow CMS to move forward as it should to optimize use of the Internet.

FFS operations are supported by a network of critical IT systems. The existing FFS claims processing system is composed of three separate shared systems⁴ for processing benefit claims by provider type and the Common Working File (CWF), a processing pre-payment validation and claims authorization system designed to check beneficiary eligibility and utilization.

Unfortunately, these systems form a patchwork built up over decades that is outdated for current and future use. The systems are unable to handle needed Medicare program changes and pose significant problems for ensuring the standardized application of program requirements. The program's continued reliance on them will create security risks and limit Medicare's ability to manage increases in beneficiaries and claims and facilitate the integration of claims data. In addition, without better integration, the impact of changes made to one system can have unpredictable results elsewhere.

⁴ In 1995, CMS designated one shared system for intermediary, carrier, and DME regional carrier claims processing. Consolidation of the shared systems has been an extended process, but will be complete in October 2005.

To improve the IT supporting Medicare, CMS is evaluating a number of options and has already undertaken several modernization initiatives. The agency is interested in maximizing its use of the Internet, which it views as an important part of improving service to providers. For example, Web-enabling many of Medicare's current business functions would reduce the administrative burden on providers, help to ensure more accurate payments, and improve agency-to-provider communication (e.g., targeting information about policy and operational changes directly to affected providers instead of sending a mass mailing to all).

The IT modernization initiatives already underway will have a major impact on both infrastructure and applications, and will result in FFS claims processing and related systems that are scalable, flexible, responsive to policy changes, supportive of queries, and maintained on platforms that facilitate easy system-to-system communication. Modernized systems will produce consistency in the use of Medicare data and predictability in systems changes, and will increase the reliability of information used by the program's stakeholders. This, in turn, will lead to improved quality of care and a better level of service for beneficiaries and providers.

Current FFS Environment

- FFS claims processing systems are outdated for current and future use
- Systems have difficulty handling Medicare program changes and ensuring standardized application of program requirements
- Poor security for Internet growth

Future FFS Environment

- Unified FFS claims system that processes all types of claims data
- Single, integrated financial accounting system to perform payment calculation, formatting, and accounting for Medicare claims
- Improved systems security

Infrastructure — Building a Modern IT Platform: Data Centers

Data centers play a key role in Medicare FFS claims processing and are a critical part of the program's IT platform. In the future FFS environment, CMS will consolidate the number of data centers to 4, from the current level of 16, and contract directly with the centers for claims processing support. This consolidation will also produce a much-needed modernization of data center operations.

Data center consolidation will enable CMS to increase its control of data center operations and secure protected health information more effectively. Consolidation will provide CMS greater flexibility in meeting current and future needs (i.e., timely implementation of policy changes), and produce cost savings resulting from economies of scale. It will also enable improvements in service levels to beneficiaries and providers through the creation of web-based services, increased access to quality data, integrated help desks and call centers, and greater control over data security and privacy. While archived data and applications may vary by data center, Medicare will achieve sufficient standardization to both enable the sharing of information and promote service continuity across data centers.

Having the new data centers operational is critical for maximum efficiency in the MAC transitions, since the existing data centers, provided mainly through current FIs and carriers, will be phasing out, and some of the information services and support to be provided by MACs are

dependent on the modernized platform. However, CMS will include a data center requirement as an option in some MAC contracts, to ensure that Medicare data center services will be available during initial MAC implementations should there be unexpected changes or delays in its data center consolidation activities.

Infrastructure — Building a Modern IT Platform: Medicare Claims Processing Redesign

Under the Medicare Claims Processing Redesign (MCPR) initiative, CMS is modernizing the FFS claims processing from end-to-end, to achieve a more standard, uniform, and streamlined environment that will better meet the program's business needs. The vision is for a unified system that processes all types of claims data, with distinct databases for beneficiaries, providers, claims data, and financial information, which will operate at all Medicare data centers.

MCPR is designed as a multi-phase, cross-agency effort over several years. Initially, CMS will determine business requirements, test system performance on an advanced technology platform, and explore additional enhancements to the claims processing environment, including both front- and back-end standardization. CMS has completed documentation of a significant portion of the business requirements and is planning the next phase of development.

Applications — Modernizing Medicare Accounting: Healthcare Integrated General Ledger Accounting System

CMS is replacing its fragmented and overlapping accounting systems, maintained by both CMS and its current Medicare FFS contractors, with the new Healthcare Integrated General Ledger Accounting System (HIGLAS) – a single, integrated financial accounting system.

Once a Medicare claim has been processed, HIGLAS, not the accounting systems currently used by Medicare contractors, will perform the payment calculation, formatting, and accounting. HIGLAS will replace the benefit accounting processes used by the Medicare contractors, enabling them to better record, track, and collect accounts receivable, which will help enhance CMS payment decision-making. As a result of HIGLAS, CMS anticipates that it will recoup an additional 1 percent of its new accounts receivables from its improved capability to record, track, and collect accounts receivables. The amount of this benefit is estimated at \$159 million returning to Medicare trust funds annually.

In the future FFS environment, MACs will be required to use HIGLAS. Some FIs and carriers will have transitioned to HIGLAS before MAC competitions get underway. For jurisdictions where transitions are not complete, CMS will provide an estimated HIGLAS implementation date for MACs in its procurement documentation.

Chapter IV: Resources and Funding

Implementing section 911 and related Medicare contracting reform initiatives will require an initial investment that will ultimately improve the quality of service to beneficiaries and providers; strengthen the delivery of coordinated, quality care; and produce greater administrative efficiency and effectiveness.

This chapter describes the funding and other resources required to achieve MMA goals for the future FFS environment as well as the resulting improvements and savings. It also includes information about the investment drivers for Medicare contracting reform, current spending levels, and projected future spending and the reform activities it will support.

Current Spending (FY 2004 – FY 2005)

CMS has allocated over \$27 million for FY 2004 and FY 2005 to fund multiple activities related to MAC implementation. These activities involve improving CMS' ability to collect and analyze data concerning current claims-processing operations, utilizing business and technical industry consultants for planning MAC procurements and transitions, gathering input from key stakeholder groups, and beginning the start-up cycle of MAC procurements and transitions.

CMS will also invest in improving the existing information management tools and tracking systems for program changes that it communicates to the FFS contractors. These technical planning and infrastructure solutions will help ensure that CMS can effectively administer a program focused on accountability and performance.

Investment Drivers for Medicare Contracting Reform

The major investment drivers for Medicare contracting reform are:

- **Transitions** resulting from competition (i.e., transferring workloads from an existing contractor to a MAC) and consolidation, from the current 51 contractors to 23 MACs (see [Direct Costs](#));
- **Performance incentives** to entice companies to devote their best resources and efforts to fulfilling the contracts and meeting high-performance standards (see [Direct Costs](#)); and
- **IT Infrastructure** to support the new contracting and operational environments (see [Indirect Costs](#)).

The largest initial investment will be the cost of transitioning the existing Medicare claims workloads. CMS will be simultaneously transitioning several MAC jurisdictions, each requiring that no fewer than 3, and as many as 9, separate portions (or segments) of current contractor workload be moved. This level of transition activity and the related closeout costs will require significant funding and staffing resources to ensure continuity of Medicare operations and service to beneficiaries and providers.

Improvements and Savings from Medicare Contracting Reform

As mentioned in the preceding chapters of this report, Medicare contracting reform will result in a number of important improvements and savings for Medicare FFS that will have a positive impact on the program’s beneficiaries and providers. The investments will help ensure the program remains an important and secure health plan option for beneficiaries well into the future. Beneficiaries will receive improved services focused on their individual needs. Collectively, improvements will enable CMS to facilitate management of care, thereby improving the overall health status of beneficiaries. Table IV-1 details savings that will result from Medicare contracting reform.

Table IV-1: Savings from Medicare Contracting Reform

| Types of Savings | Sources of Savings |
|-------------------------------------|---|
| Medicare Trust Funds Savings | <ul style="list-style-type: none"> • Reduction in claims error rate due to: <ul style="list-style-type: none"> - Integration of Parts A and B functions - Consolidation of activities into fewer contractors - Competition leading to more innovative contractors • Creation of an integrated A/B platform, facilitating potential long term savings for coordination of care |
| CMS Administrative Savings | <ul style="list-style-type: none"> • Consolidation and economies-of-scale • A more competitive contracting environment • Innovation through performance-based contracting |
| Provider Billing Expense | <ul style="list-style-type: none"> • Less staff time for providers as a result of interacting with fewer contractors • Improvement of provider education and training on Medicare billing rules • Streamlined claims payment through modernized systems |

The basic consolidation of Parts A and B into one MAC will provide immediate benefits to a number of providers who currently bill both the carrier and intermediary in their current jurisdiction; physicians operating in border areas must enroll with more than one contractor in order to serve all of their patients. The new MAC jurisdictions should largely resolve this problem. Providers will experience greater consistency in payment decisions across larger MAC jurisdictions. In addition, standardized electronic transactions and modernized IT systems will improve access to Medicare claims systems and reduce administrative time. The challenge to providers in addressing many cross-cutting issues will also be aided through the collection of responsibility and data within a single entity. Integrated administrative responsibilities will lay the foundation for paying providers based on performance to improve beneficiary care and outcomes.

Improved changes to the contracting structure will also generate savings to the Medicare trust funds. The CMS Office of the Actuary (OACT) has projected that three aspects of our Medicare contracting reform plan will lead to reduced claims processing error rates and resulting savings: the integration of Part A and Part B processing functions; the consolidation of activities into fewer contractors; and the more competitive contracting environment, which will yield the best

qualified and most innovative contractors. Assuming that the acquisition and transition schedule discussed in [Chapter III](#) is maintained, the trust fund savings resulting Medicare contracting reform will start in FY 2008, but will accumulate rapidly to a total of \$900 million by the end of FY 2010.

Over time, CMS will also recognize savings over its existing operations. Competition and re-competition will promote the acquisition of Medicare administrative services at market prices, while maintaining the high quality of services to providers and beneficiaries. Incentives will enable CMS to gain further improvements in the quality of services through rewarding better performance. As MACs improve their operations and effectiveness, CMS management of the contracts will also become more efficient and effective; therefore, some staff may be able to be redeployed to other critical Medicare efforts.

In addition, IT modernization improvements have a positive impact on the program itself. Improved data integration, for example, will provide CMS the tools it needs to more aggressively combat Medicare fraud and abuse. It enables the agency to obtain data that will lead to the creation of better payment systems and methodologies

Future Spending (FY 2006 and Beyond)

Spending during the initial implementation period (FY 2006 – FY 2011) can be categorized as direct and indirect. Direct costs (e.g., transition and termination costs) are those categories of costs that will necessarily be incurred, regardless of how CMS implements section 911. Indirect costs (e.g., FFS data center migration) are those categories of costs that will be incurred for activities and initiatives that support the most efficient and effective way of implementing section 911 for the overall Medicare FFS program, minimizing risks that may threaten continuity of providing services under this program.

The President's Budget for FY 2006 requests \$58.8 million in discretionary funds to support the implementation of Medicare contracting reform. The plan set forth in this Report will require a substantial additional investment in subsequent years, particularly in FYs 2007 and 2008. These resources will be needed in order to fund a number of critical transition activities, including costs associated with the close-out of the current Medicare FI and carrier contracts. The out-year cost estimates are consistent with Congressional Budget Office cost estimates relating to the legislative proposals that evolved into section 911 of MMA.

Although Medicare contracting reform requires a significant up-front investment, this initiative will also generate significant trust fund and administrative savings over time. Assuming that the transition schedule discussed in [Chapter III](#) is maintained, the trust fund savings resulting from Medicare contracting reform will start in FY 2008 and will accumulate rapidly to a total of \$900 million by the end of FY 2010.⁵ Beyond FY 2011, CMS projects that administrative savings, in the form of contractor cost reductions from the competitive contracting environment, could exceed \$100 million annually.

⁵ The CMS Office of the Actuary projects trust fund savings of \$70 million in FY 2008, \$280 million in FY 2009, and \$550 million during FY 2010.

The investment in Medicare contracting reform immediately begins to accrue savings at a rapid rate. CMS projects that administrative savings, in the form of contractor cost reductions from the competitive contracting environment, will begin to accrue in FY 2007 and could exceed \$100 million annually beyond 2011. Assuming that the transition schedule discussed in Chapter III is maintained, CMS projects that cumulative administrative savings could exceed the investment and ongoing costs of the MAC environment before the end of FY 2013. This administrative payback is achieved through improved management and consolidation of the Medicare FFS program.

Discussion of Direct Costs

The three direct costs inherent in the legislation are those associated with transitioning current workloads, conducting provider satisfaction surveys, and paying incentives to those contractors who meet or exceed performance expectations. In addition to these costs, CMS will incur additional costs as it seeks to ensure continuity in its operations through changes to its contract performance period and improvements to its IT systems.

Transition Costs

CMS incurs significant expenses when a Medicare contractor leaves the program and another contractor takes on its work. These expenditures cover a wide range of tasks required to establish the incoming contractor operation and physically move the workload, while ensuring continuity of excellent provider and beneficiary service. Due to the dictates of the Title XVIII authority, CMS is also required to incur outgoing contractor closeout costs such as lease termination, equipment depreciation and personnel expenses (e.g., retention, severance and pension funding). These closeout costs represent a significant portion of the estimated MAC transition costs. While section 911 of MMA expands CMS' contracting authority, enabling it to avoid incurring these closeout costs for contracts let under the new authority, during the period CMS is moving from the current contracts to MAC contracts (FY 2006-2011), this considerable financial obligation remains.

The anticipated year-by-year MAC transition costs will reflect the following strategy:

- Costs will be lowest during the start-up cycle (2006 – 2007) as CMS undertakes relatively small and moderately difficult implementations in order to learn the best management approach for implementing the new contracts.
- Transition/termination costs will rapidly increase as CMS undertakes the most difficult contract implementations during 2008 and 2009.

Because payment for many closeout costs is mandated only for current Title XVIII contracts, and will not be required for future FAR contracts, this is a one-time expense associated with establishing the future FFS environment.

Performance Incentives and Provider Surveys

The MMA gives the CMS Administrator the ability to pay MACs monetary incentives to motivate desired contractor performance.

MACs will compete for and manage very challenging contracts. They will require difficult transitions involving new consolidated Medicare service areas that are generally larger and have broader responsibilities (i.e., more states, providers, and beneficiaries) than those currently in place. But if they meet or exceed the performance metrics defined in their contracts, MACs will have an opportunity to earn profits through performance incentives.

The Medicare contractor incentive pilot conducted in FY 2003 and 2004 demonstrated that incentives clearly influence contractor performance. CMS expects to pay award fees to MACs for exemplary performance, and significant work is underway with the MAC SOW development effort to learn from the 2003 and 2004 incentive pilots and determine how best to use incentives to achieve improvements in the program in the MAC contracts.

Section 911 of the MMA also requires that provider and beneficiary satisfaction with the services provided by a MAC be weighed when evaluating a MAC's performance. Therefore, costs to conduct provider satisfaction surveys are required, in addition to payment of performance incentives.

CMS expects to survey providers and pay incentives for good performance every year, making this an ongoing cost that will be offset by operational and programmatic savings.

Discussion of Indirect Costs

CMS will incur additional costs as it seeks to ensure continuity in its operations.

Contracting Reform IT Needs

As described in [Chapter III](#), a network of IT systems supports Medicare's FFS operations. However, the current systems are unable to handle the changes brought about by Medicare contracting reform. CMS' continued reliance on these systems would not only hinder services to beneficiaries and providers, but also pose significant security risks.

Therefore, to ensure the success of Medicare contracting reform, CMS plans to modernize its IT systems to support the new FFS environment. The largest portion of this expense will be incurred through the migration of the current FFS data centers to the enterprise data centers. In addition, CMS expects to incur costs in order to maintain contractor information and management databases.

Modernized systems will allow for more consistent, reliable information for both CMS and its stakeholders, promoting improved quality of care and better levels of service for beneficiaries and providers. Through its IT modernization initiatives, CMS will recognize savings through increased use of the Internet for various administrative functions. For example, providers will be able to check claims status via a secure Internet connection rather than phone in their inquiry. Through this modernized approach, CMS will recognize savings on less complex inquiries (i.e., whether a claim has been paid) while contractor staff will be able to focus on more involved, time-consuming inquiries (i.e., status of a claim that has been appealed).

Contractor Compliance Programs and Technical Support

CMS anticipates that the new contracts will include significant compliance program requirements and estimates that these requirements will increase the operating cost of the MACs when fully phased-in. Strong compliance programs will ensure that the potential for integrity problems is counteracted.

CMS will also need a modest level of technical and business consulting support for the duration of the MAC phase-in.

Other Budget Issues

Period of Performance of Medicare Contracts

Since Medicare administrative funding is subject to the annual appropriation process, CMS' current contract periods coincide with the federal fiscal year. This means that in most years, we operate under a Continuing Resolution for some period of time at the beginning of the year. While HHS could grant CMS the authority to incrementally fund the MAC contracts during this time, it presents challenges for effective administration of performance-based contracts. In order for CMS to hold contractors accountable for performance, contractors must be able to negotiate their yearly costs prior to the beginning of their contract period in order to maximize resources and, therefore, performance.

To avoid this significant risk, CMS plans to move the period of performance for Medicare contracts to a calendar year cycle. Adjusting the period of performance will not increase or decrease overall or net administrative outlays. CMS will still be paying for the same underlying Medicare benefit administration functions at the same level of effort. However, it will require additional budget authority during the transition period to account for the overlap beyond the end of the fiscal year. This is a one-time action, with all subsequent contract periods based on a calendar year.

Without this change, CMS would be forced to incrementally fund the new performance-based contracts, based on the duration provided for in continuing resolutions. This situation would present many administrative and programmatic concerns for both CMS and the MACs.

Chapter V: Key Accomplishments to Date

CMS has been anticipating changes in Medicare's administrative structure for several years. It has completed much of the necessary analysis, particularly related to jurisdictional arrangements and the structure and timing of MAC competitions, and conducted two years of pilot contracting arrangements involving performance measures and incentives. The agency is confident these efforts will help it to successfully implement Medicare contracting reform.

This chapter describes CMS' significant work accomplishments to date in several key areas related to Medicare contracting reform implementation.

Communication and Consultation

Open communication with stakeholders is important to the successful implementation of Medicare contracting reform, which has a wide range of stakeholders directly involved in or affected by the development of the future FFS environment. Misunderstandings about project goals and the failure to obtain buy-in could potentially impede the progress of initiatives such as the MAC transitions.

CMS is committed to providing as much information as possible to Medicare contracting reform stakeholders. The agency has already developed a formal communications plan and a Medicare contracting reform website⁶. The website, which went live in March 2004, provides a forum for CMS to rapidly share information and solicit input from interested companies, providers, and beneficiaries. In its first five months of operation, the site received roughly 32,000 hits. Recently, the website was updated to include standard Q & A's on Medicare contracting reform in response to stakeholder feedback.

The MMA requires that CMS consult with providers, beneficiary organizations, and others on the development of performance requirements and standards for MACs. On April 15, 2004, CMS held the first of these consultations by hosting a Provider Open Door Forum⁷. Over 500 people participated via telephone and in-person at CMS' headquarters in Baltimore, Maryland. In addition to input received through the forum, CMS encouraged providers to submit additional comments through the Medicare contracting reform website. The agency cataloged all the comments received, and staff is actively reviewing them as they draft the MAC statement of work. CMS has also participated in meetings on five occasions between June and October with smaller groups of providers. At these meetings, CMS staff has presented information comparable to that provided at the April Open Door Forum and has encouraged providers to give feedback and ideas.

In addition to provider consultations, CMS has started to consult with beneficiaries and other groups through a variety of media. On May 24, 2004, CMS sent a notice via e-mail listserv requesting input from beneficiary organization representatives. The agency has also held face-to-face meetings and conference calls with representatives from the State Health Insurance and

⁶ The Contracting Reform website is available at www.cms.hhs.gov/medicarerreform/contractingreform/.

⁷ For additional information on this forum, including a summary of comments received, go to www.cms.hhs.gov/medicarerreform/contractingreform/odf.

Assistance Program, various advocacy groups, the AARP and the National Medicare Education Program Coordinating Committee. In 2003, CMS held conference calls with current FFS contractors and other purchasers of health care. In 2004, CMS has met in the spring and late fall with executives of the current Medicare FFS contractors during which they were encouraged to individually submit questions and concerns about Medicare contracting reform to CMS. On November 9, 2004, CMS held a meeting for all interested systems industry entities during which CMS made a presentation on Medicare contracting reform.

This report is also an important communication tool for providing information to Congress and the public about the agency's planning activities. Once Congress receives this report, CMS intends to hold several town hall meetings to communicate its plans for Medicare contracting reform implementation and solicit feedback from the industry.

MAC Statement of Work Development

Unlike the current FIs and carriers, whose work requirements stem from numerous regulatory and administrative publications such as program manuals, MACs will bid on, and be held to, requirements articulated in a formal SOW.

Since 2003, CMS staff has been examining existing work requirements in order to develop a MAC SOW. The MAC SOW will focus on the desired outcomes that CMS expects from its contractors, with a strong focus on performance management. Therefore, requirements in the MAC SOW must be complete, clear, accurate and feasible; and they must produce results. CMS must choose the most appropriate set of requirements to ensure efficient administration and achieve program goals.

The DME and Primary A/B MAC SOWs for the start-up cycle of competitions are in the final stages of completion. CMS expects to release drafts of both SOWs by early 2005 for public comment.

MAC Acquisition Strategy and Plan

Before publishing the MAC SOW in a formal RFP, CMS must develop its overall acquisition strategy and plan. The acquisition strategy and plan will contain details for awarding MAC contracts and transitioning the associated workloads. In addition, it will address key elements such as contract type and term, pre-qualification requirements for MACs, performance measures and incentive plans, methods for maintaining competition, and bid evaluation criteria.

CMS has done extensive work toward outlining a MAC acquisition strategy and plan. The MAC Procurement and Transition Schedule ([Appendix C](#)), which identifies a start-up acquisition and transition cycle and two additional cycles of competition/transition activities for the initial implementation phase, is a product of this effort.

MAC Implementation Strategy

While the acquisition strategy and plan deals largely with identifying capable contractors, the implementation strategy focuses on transitioning the workloads and business processes to new MACs. The transition process will begin immediately following contract awards. The large number of procurements and transitions that must occur for CMS to fully implement the MACs

means that the agency must design a strategy to monitor activities so that operations are not at risk.

Contractor transitions are not new. CMS has regularly transitioned FFS workloads and functions. Since 1990, it has transitioned at least one contractor's workload in 13 of the past 15 years. These transitions took an average of 6 to 9 months, with some lasting as long as 1 year.

However, MAC transitions will be more complex and larger than past contractor transitions. Challenges will include new geographic jurisdictions; involuntary transitions (some companies will lose competitions); and the prospect of companies new to Medicare operations becoming MACs. Therefore, CMS has developed goals for transitioning FFS workloads. They are to:

- Minimize disruption to beneficiaries, providers, physicians, and suppliers;
- Prevent disruption of claims processing and Medicare operations;
- Complete transition activities within the required time period;
- Ensure that costs represent effective and efficient use of resources; and
- Ensure that all parties with an interest in the transition (direct or indirect) are kept informed of the transition's status and progress.

CMS has developed an overall transition strategy that addresses necessary transition activities and prerequisite tasks and interdependencies that may affect a transition schedule. The strategy outlines the award of MAC contracts and the transition of current FI, carrier, DME and HH workloads over a 55-month period, beginning in March 2005 with the release of the initial MAC RFP.

CMS recently seized the opportunity to gain valuable experience with competing FFS workload and generate lessons learned for use in the MAC competitions. In 2003, the FI serving the states of Washington and Alaska announced its intention to withdraw from the Medicare program. While the new MAC authority is not yet effective, CMS chose to award this workload to a new contractor through a limited competition (within current contracting authorities). For the first time, CMS opened the competition to existing carriers in addition to existing FIs. Upon receipt and evaluation of all proposals, the workload was awarded to a carrier - another first for the agency.

MAC Jurisdiction Development

Designing the 15 MAC jurisdictions has been a major effort for CMS. The existing FI and carrier jurisdictions do not balance claims workload, and have created disparities in resource allocation and oversight. Single contractors have been responsible for multiple states with no relation other than the award of workload by CMS. Some states have seen splits in claims processing responsibility where multiple contractors serve the same provider and beneficiary populations within a single state.

Since it would derive little benefit from maintaining the current jurisdictional structure, CMS designed 15 geographical jurisdictions for MACs based on the concept of integrated Part A and Part B claims processing, with claims and services related to a single beneficiary being processed at a single MAC. The jurisdictions are designed to reasonably balance distributions of FFS

beneficiaries, practitioners and claims volumes. Furthermore, the jurisdictional lines reflect an attempt to minimize the disruption of current interstate payment flows by enclosing, within jurisdictions, areas where large numbers of beneficiaries and claims payments cross state boundaries.

CMS believes jurisdictions that preserve state boundaries will help the agency to better oversee the performance of MACs. However, CMS recognizes that there may be a business need to cross state boundaries so that claims payment is not disrupted. For example, a chain provider who operates in multiple states may need to cross boundaries in order to bill a single MAC for services provided to a beneficiary.

Business Reengineering

In order to meet the demands of Medicare contracting reform implementation and ongoing management of the future FFS environment, CMS must reengineer some of its existing business practices and processes. The agency is in the process of cataloging and documenting existing processes, determining where changes are needed, and researching other existing processes for applicability.

One example of the agency's work in business reengineering is its structuring of CMS central and field office staff to manage the new, tightly controlled FAR contracts. These contracts require structures of authority that include a contracting officer, project officer, and government task leaders. While CMS currently administers some types of FAR contracts, MACs will greatly surpass any experience the agency has had in terms of contract size and complexity. CMS is developing plans for the realignment of its organization, including revisions to the roles of central and regional office components, to support this new activity.

CMS also needs to change the way it pays FFS contractors. Future FAR contracts will involve a process of invoicing, or vouchering, for services. CMS then must approve and make payments for the vouchers. In contrast, existing carriers and FIs under the current system are allocated a target budget, and estimated funds are made available for contractors to draw from on a monthly basis. CMS manages the receipt and approval of vouchers for most of its existing FAR contracts using a paper/manual process. An automated system will be necessary for receiving and tracking the volume, size, and frequency of the MAC vouchers. In spring 2004, CMS began a feasibility study to determine whether it can modify existing IT systems to meet these needs or will need to develop a new system. CMS anticipates the completion of the study by spring 2005.

In addition, the FAR requires contractors to comply with established Cost Accounting Standards (CAS). CMS anticipates no significant deviations from the CAS requirements. Further, CMS is in the process of evaluating other potential certification and compliance requirements (e.g., ISO certification).

Project Interactions

CMS has begun a strong effort to integrate the planning and scheduling of several major FFS projects, which will require substantial agency resources. Currently, CMS is examining basic project requirements and interdependencies to prevent any disparities in resource allocation that could hinder individual project implementations. CMS is also developing a structured approach

for prioritizing agency initiatives so that it can make resource tradeoffs. Even with adequate funding, each project will require cross-organization staff, regional expertise, and participation of Medicare contractor personnel to succeed. CMS will examine and plan for these needs to ensure the successful completion of key FFS improvements.

Conclusion

CMS recognizes the potential for improving the efficiency and effectiveness of our services to Medicare beneficiaries and providers through the Medicare contracting reform provisions contained in section 911. Through its plan for implementing these provisions, CMS expects to realize significant performance improvements. This future environment will also generate substantial savings, both administrative and programmatic, for the Medicare program. Although Medicare contracting reform requires a significant up-front investment, this initiative will also generate significant administrative savings over time as well as \$900 million in trust fund savings through FY 2010.

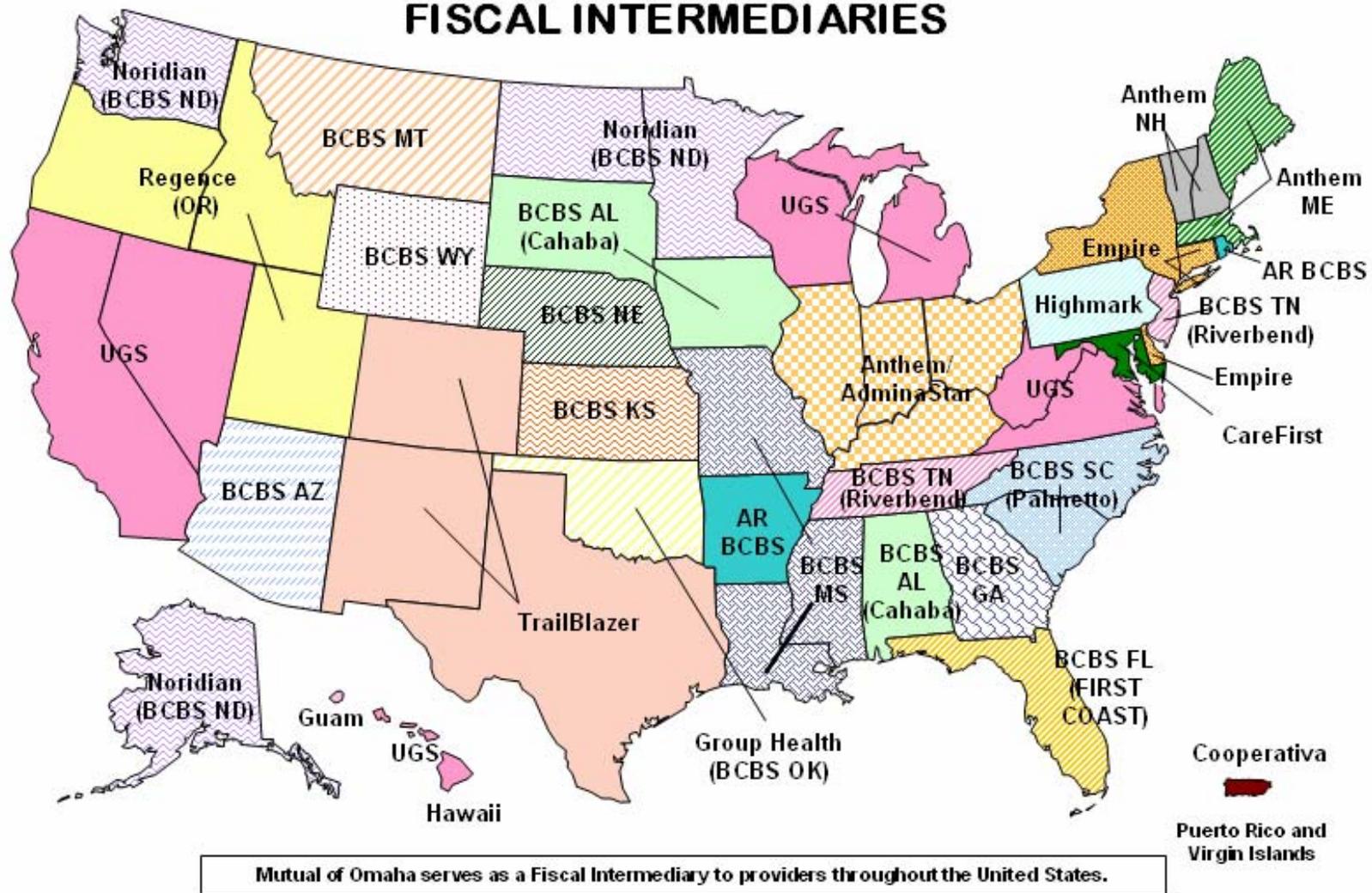
Medicare contracting reform allows for the competition of the Medicare FFS work to a broader range of contractors, promoting innovation and higher performance in the delivery of health care services. CMS will combine the FFS Part A and B workloads under the new MAC contracting authority to help achieve comprehensive care for its beneficiary community. Certain specialty workloads will be assigned and competed to functional contractors in order to guarantee high levels of service and performance around a single program function (i.e., second level appeals). Further, CMS will launch additional initiatives, such as IT modernization and the consolidation of data centers, to support the Medicare contracting reform provisions and create a reliable Medicare platform for the future.

Appendix A: Current Contractor List

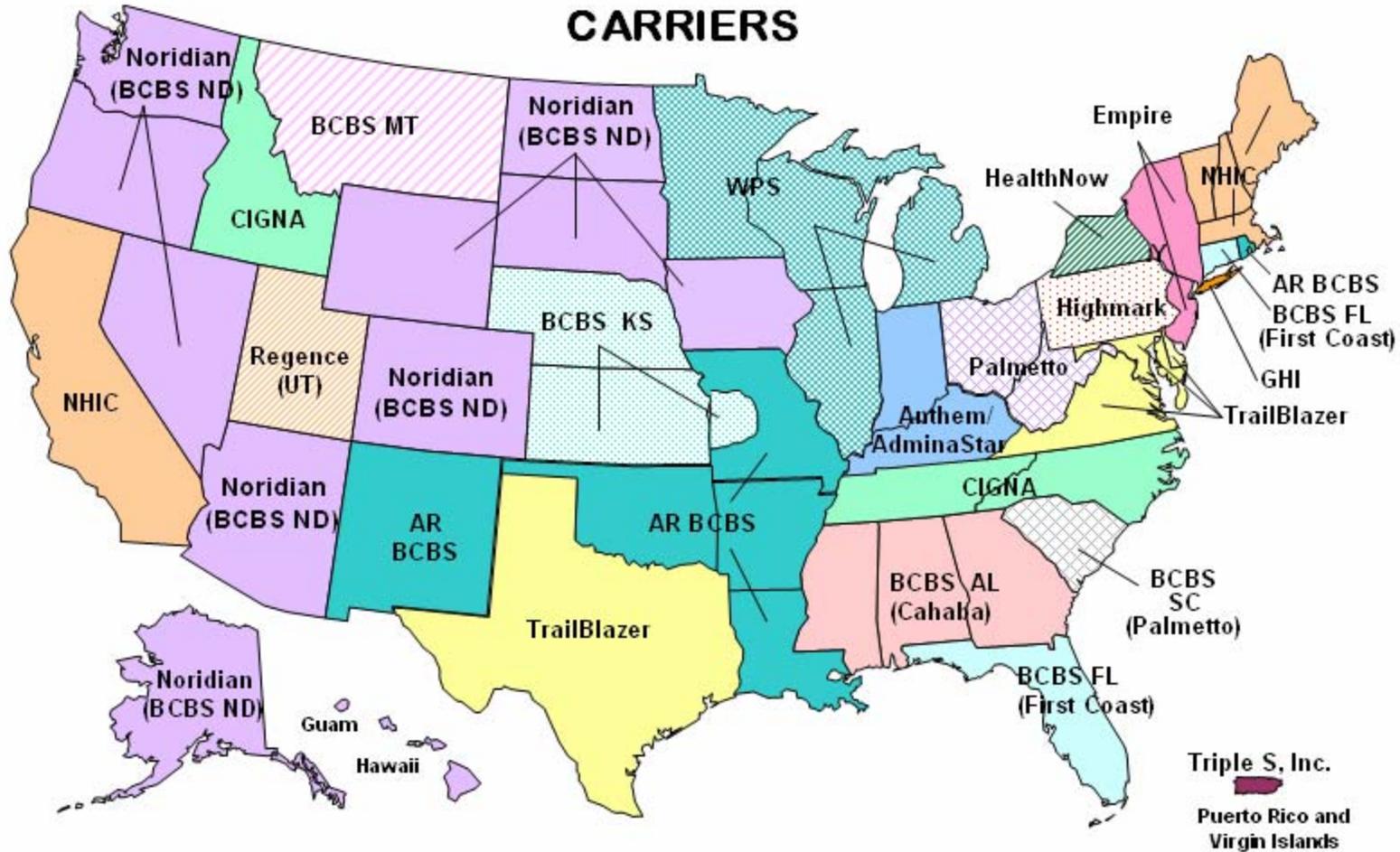
| Contractor Name | FI | RHHI | Carrier | DMERC |
|---|-----------|-------------|----------------|--------------|
| <i>Anthem Health Plans of Maine, Inc.</i> | X | X | | |
| <i>Anthem Health Plans of New Hampshire, Inc.</i> | X | | | |
| <i>Anthem Ins. Co, Inc./AdminaStar Federal, Inc.</i> | X | | X | X |
| <i>Arkansas BCBS</i> | X | | X | |
| <i>BCBS of Alabama (Cahaba)</i> | X | X | X | |
| <i>BCBS of Arizona, Inc.</i> | X | | | |
| <i>BCBS of Florida (First Coast Service Options) (FCSO)</i> | X | | X | |
| <i>BCBS of Georgia, Inc.</i> | X | | | |
| <i>BCBS of Kansas, Inc.</i> | X | | X | |
| <i>BCBS of Mississippi (Trispan)</i> | X | | | |
| <i>BCBS of Montana, Inc.</i> | X | | X | |
| <i>BCBS of Nebraska</i> | X | | | |
| <i>BCBS of South Carolina (Palmetto G.B.A.)</i> | X | X | X | X |
| <i>BCBS of Tennessee (Riverbend)</i> | X | | | |
| <i>BCBS of Wyoming</i> | X | | | |
| <i>CareFirst of Maryland, Inc.</i> | X | | | |
| <i>Connecticut General Life Ins. Co. (CIGNA)</i> | | | X | X |
| <i>Cooperativa de Seguros de Vida de Puerto Rico</i> | X | | | |
| <i>Empire Health Choice Assurance, Inc. (Empire BCBS)</i> | X | | X | |
| <i>Group Health Inc. (GHI)</i> | | | X | |
| <i>Group Health Service of Oklahoma (BCBS of OK)</i> | X | | | |
| <i>HealthNow New York, Inc. (Western NY BCBS)</i> | | | X | X |
| <i>Highmark, Inc. (HGS Administrators) (HGSA)</i> | | | X | |
| <i>Highmark, Inc. (Veritus Medicare Services)</i> | X | | | |
| <i>Mutual of Omaha Insurance Company</i> | X | | | |
| <i>National Heritage Insurance Co. (NHIC)</i> | | | X | |
| <i>Noridian Mutual Insurance Company (BCBS of ND)</i> | X | | X | |
| <i>Regence BCBS of Oregon</i> | X | | | |
| <i>Regence BCBS of Utah</i> | | | X | |
| <i>TrailBlazer Health Enterprises, LLC</i> | X | | X | |
| <i>Triple S, Inc.</i> | | | X | |
| <i>United Government Services, LLC (UGS)</i> | X | X | | |
| <i>Wisconsin Physicians Service Insurance Company (WPS)</i> | | | X | |
| TOTAL | 25 | 4 | 18 | 4 |

Appendix B: Current Jurisdictional Maps

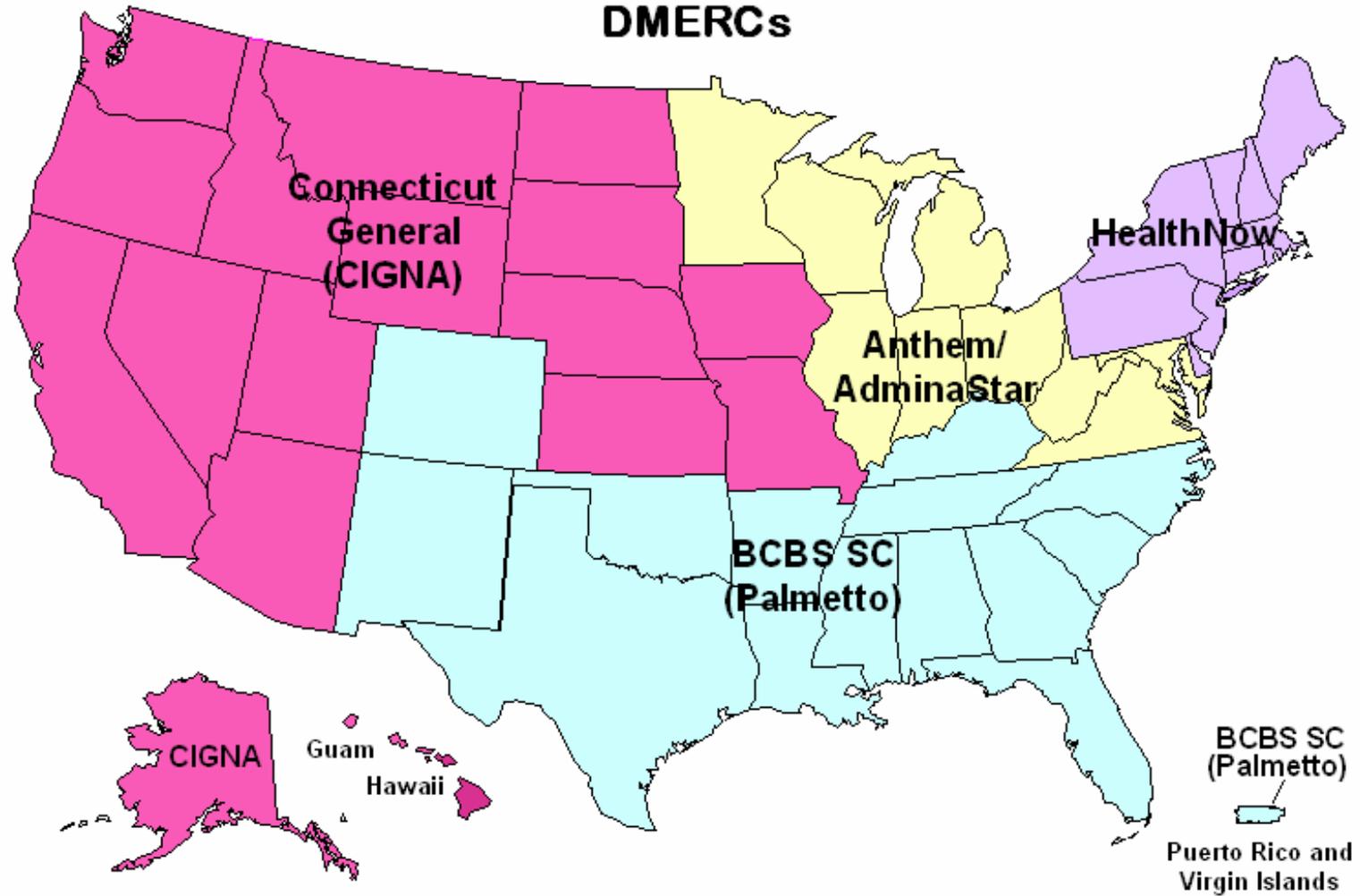
CURRENT CONTRACTING ENVIRONMENT: FISCAL INTERMEDIARIES



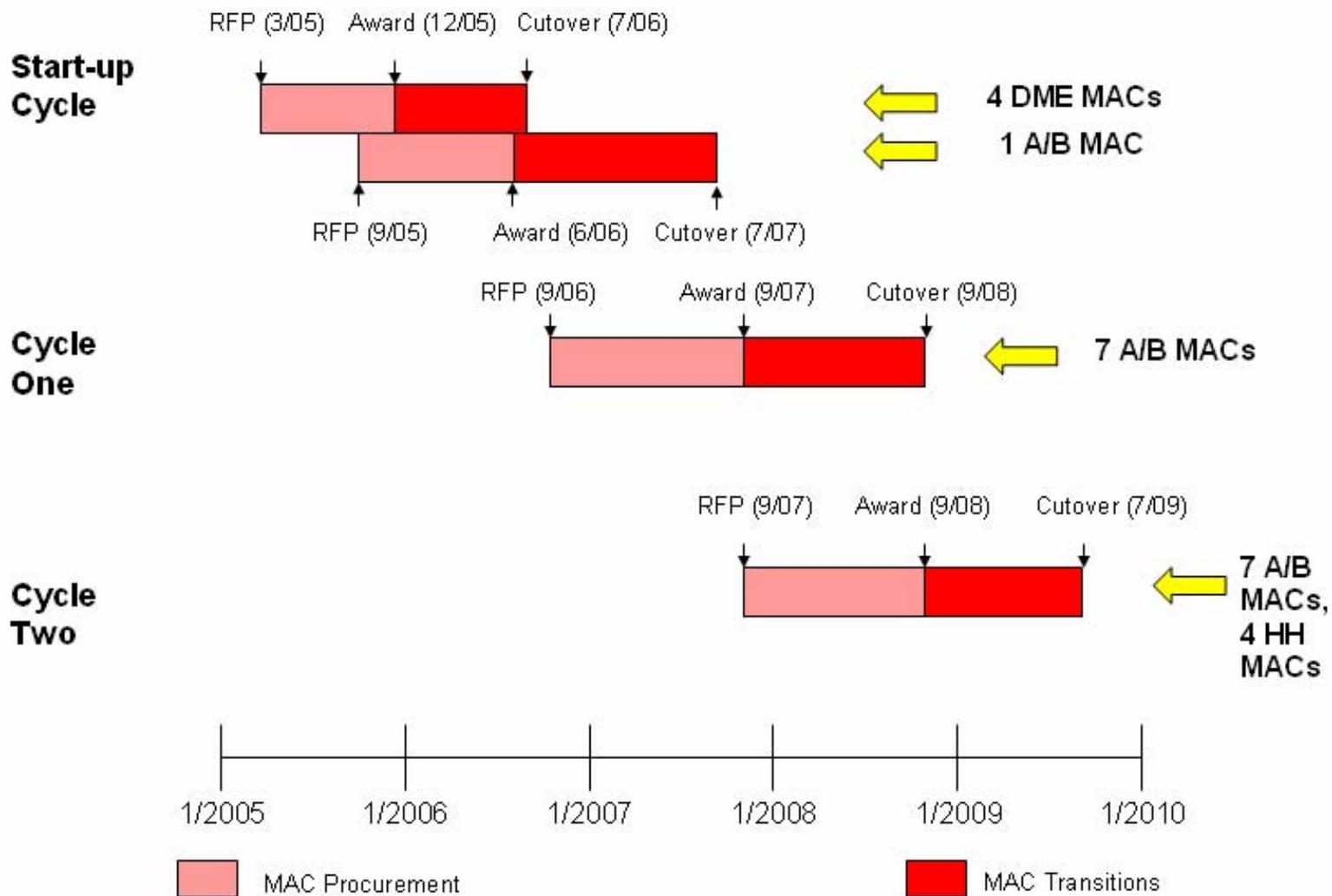
CURRENT OPERATIONAL ENVIRONMENT: CARRIERS



CURRENT CONTRACTING ENVIRONMENT: DMERCs



Appendix C: MAC PROCUREMENT AND TRANSITION SCHEDULE



Note: CMS transition monitoring continues for three months post cutover.

Appendix D: ACRONYMS

BCBS: Blue Cross Blue Shield
BCC: Beneficiary Contact Center
CMS: Centers for Medicare & Medicaid Services
CO: Central Office
COB: Coordination of Benefits
DME: Durable Medical Equipment
DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics and Suppliers
DMERC: Durable Medical Equipment Regional Carrier
FAR: Federal Acquisition Regulation
FFS: Fee-for-Service
FI: Fiscal Intermediary
FY: Fiscal Year
GAO: U.S. Government Accountability Office
HH: Home Health & Hospice
HHA: Home Health Agency
HHS: U.S. Department of Health and Human Services
HIGLAS: Healthcare Integrated General Ledger Accounting System
HIPAA: Health Insurance Portability & Accountability Act
ISO: International Organization for Standardization
IVR: Interactive Voice Response
MAC: Medicare Administrative Contractor
MCPR: Medicare Claims Processing Redesign
MCR: Medicare Contracting Reform
MIP: Medicare Integrity Program
MMA: Medicare Modernization Act
NGD: Next Generation Desktop
OACT: CMS Office of the Actuary
PSC: Program Safeguard Contractor
QIC: Qualified Independent Contractor
RFP: Request for Proposal
RHHI: Regional Home Health Intermediary
RO: Regional Officer/Regional Office
RRB: Railroad Retirement Board
SCHIP: State Health Insurance and Assistance Program
SNF: Skilled Nursing Facility
SNF: Skilled Nursing Facility
SOW: Statement of Work

Appendix E: DEFINITIONS

Acquisition – The process by which the government issues a request for proposals on proposed contract work, reviews proposals, selects a winning proposal, awards a contract, and the new contractor sets up for work and begins operations.

Beneficiary – A person who has health insurance through the Medicare program.

Beneficiary Contact Center (BCC) – A customer service center handling telephone and written inquiries from Medicare beneficiaries and their authorized representatives.

Blue Cross and Blue Shield Association (BCBSA) – An association that represents the common interests of Blue Cross and Blue Shield health plans.

Benefits Improvement Protection Act of 2000 (BIPA) – Established statutory requirement for Qualified Independent Contractors.

Carrier – A private company that has a contract with CMS to pay Medicare Part B claims.

Centers for Medicare & Medicaid Services (CMS) – The HHS agency responsible for administering the Medicare program.

Chain Provider – A group of institutional providers commonly owned and usually having billing services at a home office location.

Common Working File (CWF) – A data file used by fiscal intermediaries and carriers to check beneficiary eligibility.

Competition – A contract action where two or more responsible sources, acting independently, can be solicited to satisfy the Government's requirement.

Compliance Program – Internal program designed to ensure adherence to laws, regulations, and business policies.

Consolidation – The realignment of workloads to increase the size and responsibility of administrative contracts and reduce the number of entities CMS must oversee.

Contracting Officer – A person with the authority to enter into, administer, and/or terminate contracts and make related determinations and findings.

Contracting Reform – 1. Section 911 of the MMA.
2. The initiative pursued by CMS to revise Medicare contracting strategy to improve claims administrative and benefit management services for the Medicare FFS program⁸.

⁸ In order to further clarify and create a visual recognition for its stakeholders, CMS refers to this initiative as Medicare Contracting Reform (MCR).

Coordination of Benefits Contractor (COB) – A private company that contracts with CMS to determine whether some other plan or insurance policy will pay first, before Medicare.

Cost Accounting Standards (CAS) – Requirements established by FAR for the accounting of costs associated with government contracts.

Data Center – Medicare entity that houses claims processing software systems for Medicare claims.

Durable Medical Equipment (DME) – Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicare. DME is paid for under Medicare Part B.

Durable Medical Equipment Regional Carrier (DMERC) – A private company that contracts with CMS to pay bills for durable medical equipment.

Federal Acquisition Regulations (FAR) – Government standards by which federal procurement and contracting actions must be performed.

Fee-For-Service (FFS) – [See Medicare Fee-For-Service.](#)

Fiscal Intermediary (FI) – (also referred to as an **Intermediary**) – A private company that has a contract with CMS to pay Part A bills and some Part B claims.

Fiscal Year (FY) – The period that runs from October 1st through September 30th of the following year. The government follows a budget that is planned for a fiscal year.

Functional Contractor - A Medicare contractor that performs a limited Medicare function on a national or regional basis, such as coordination of benefits, statistical analysis, etc.

Healthcare Integrated General Ledger Accounting System (HIGLAS) – Financial management system that tracks payment of Medicare claims.

Home Health (HH) – Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury.

Home Health Agency (HHA) - An organization that provides home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Incentives – Opportunity under a contract to earn additional money by meeting particular requirements or exceeding performance requirements.

Integration – Combining claims processing responsibility for Part A and Part B claims under the responsibility of one contract.

Intermediary – [See Fiscal Intermediary](#).

Internal Controls – Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment.

Medicare Administrative Contractor (MAC) – A private entity that Medicare will contract with under section 1874A of the Social Security Act, as added by the MMA, for Medicare claims processing and related services under the MMA.

Medicare Advantage (MA) - A Medicare program that gives choices among health plans, designed after managed care delivery. Formerly known as Medicare + Choice.

Medicare Claims Processing Redesign (MCPR) – Initiatives by CMS to redesign and modernize its claims processing systems.

Medicare contractor – A Medicare Part A FI, a Medicare Part B Carrier, a Regional Home Health Intermediary (RHHI), or a Medicare Durable Medical Equipment Regional Carrier (DMERC).

Medicare Fee-For-Service (FFS) – (also known as the **Original Medicare Plan**) – A pay-per-visit health plan that pays for services provided to beneficiaries by any doctor, hospital, or other health care provider who accepts Medicare payment. Medicare FFS has two parts: Part A (hospital insurance) and Part B (medical insurance).

Medicare Integrity Program (MIP) – The program established by Congress through the Health Insurance Portability and Accountability Act of 1996 to fight fraud and abuse in the Medicare program.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) – The legislation passed by Congress in 2003 that requires contracting with Medicare Administrative Contractors and other provisions, including the establishment of a prescription drug benefit.

Next Generation Desktop (NGD) – A government furnished, web-based customer service desktop application.

Open Door Forums – Regular meetings held by CMS to discuss current Medicare issues with interested entities, groups and persons.

Original Medicare – [See Medicare Fee-For-Service](#).

Part A – (also referred to as **Medicare Hospital Insurance**, or **HI**) – The hospital insurance portion of Medicare. It was established by section 1816 of Title XVIII of the Social Security Act of 1965, as amended, and covers inpatient hospital care, skilled nursing facility care, some home health care services, and hospice care.

Part B – (also referred to as **Medicare Supplementary Medical Insurance**, or **SMI**) – The supplementary or "physicians" insurance portion of Medicare. It was established by section 1842 of the Title XVIII of the Social Security Act of 1965 as amended, and covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare.

Performance Metrics – A gauge used to assess the performance of a process or function of any organization.

Physician – An individual licensed under state law to practice medicine or osteopathy.

Procurement – An activity whereby CMS acquires a new contractor for services.

Program Safeguard Contractor (PSC) – A private entity that has a contract with CMS to perform program safeguard activities, such as fraud detection and prevention and data analysis. It was established under the Medicare Integrity Program (MIP).

Project Officer – An appointed person who supports the contracting officer and is responsible overall for a project.

Provider –

1. Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare.
2. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

Qualified Independent Contractor (QIC) – A private entity that has a contract with CMS to perform second level appeals of Medicare claims determinations.

Regional Home Health Intermediary (RHHI) - A private company that contracts with Medicare to pay home health and hospice bills and check on the quality of home health care.

Regional Office (RO) - CMS has 10 ROs that work closely with Medicare contractors in their assigned geographical areas on a day-to-day basis. Four of these ROs monitor Network contractor performance, negotiate contractor budgets, distribute administrative monies to contractors, work with contractors when corrective actions are needed, and provide a variety of other liaison services to the contractors in their respective regions.

Secretary - The Secretary of Health and Human Services.

Skilled Nursing Facility (SNF) – A facility (which meets specific regulatory certification requirements) which primarily provides inpatient skilled nursing care and related services to

patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Supplier – Generally, any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.

Transition – An activity whereby CMS moves work from one administrative contractor to another and the incoming contractor officially takes over work functions.

Workload – The total work performed by a Medicare claims processing contractor, usually expressed as the number of claims processed on a yearly basis.